DUTCHESS
COMMUNITY COLLEGE

HEALTH OFFICE

HEALTH REPORT AND PHYSICIANS CERTIFICATE

COMPLETED PHYSICAL MUST BE SUBMITTED ON ORIGINAL DCC FORM.
Please retain a photocopy for personal record.

Please print or type all information:

Program: _____ **A#** _____

Name: _____ **Date of Birth:** _____

Address: _____
Street **City** **State** **Zip Code**

Phone Number: _____
House **Cell**

Emergency Contact: _____
Name **Relationship** **Number**

Personal History: Please check all boxes that apply

- ☐ Vision Problems
- ☐ Speech Disorder
- ☐ Epilepsy
- ☐ Allergic Rhinitis
- ☐ Asthma
- ☐ Tuberculosis
- ☐ Positive TB skin test

- ☐ Fever
- ☐ Weight Gain/Loss
- ☐ Fatigue
- ☐ Fainting
- ☐ Thyroid Disease
- ☐ Kidney disease
- ☐ Diabetes

- ☐ Sexually transmitted disease
- ☐ Hepatitis
- ☐ Skin Disease
- ☐ Rash
- ☐ Headache
- ☐ Hernia

- ☐ Orthopedic Problem
- ☐ Arthritis
- ☐ Back injury
- ☐ Neck/back pain
- ☐ Joint Pain

- ☐ Intestinal Disorder
- ☐ Gastritis
- ☐ Loss of Appetite
- ☐ Nausea
- ☐ Heartburn
- ☐ Abdominal Pain
- ☐ Diarrhea
- ☐ Constipation

- ☐ Heart disease
- ☐ Hypertension
- ☐ Shortness of breath
- ☐ Cough/wheeze
- ☐ Chest pains
- ☐ Palpitations

- ☐ Psychiatric Problems
- ☐ Anxiety
- ☐ Depression
- ☐ Insomnia

- ☐ Hospitalization
- ☐ Surgeries

Habits (times per day)

Caffeine: _____

Smoking: _____

Alcohol: _____

Exercise: _____

Allergies (food, medication, environmental): _____

List all medications taken regularly: _____

Explanation to above checked areas: _____

_____

The information provided is accurate and complete to the best of my knowledge. I give permission to send this information to Dutchess Community College and to release this information to the clinical site where I am assigned.

STUDENT SIGNATURE _____ DATE _____

PARENT SIGNATURE (IF STUDENT IS UNDER 18 YEARS OF AGE) _____ DATE _____

Name _____ A#_____

To be completed by Health Care Professional

Immunization/Disease	Vaccine Date	Disease History (Medically Documented)	Titre Date	Titre Result* Attach all laboratory records
MMR	#1 _____ #2 _____			
MEASLES	#1 _____ #2 _____	_____	_____	_____
MUMPS	#1 _____	_____	_____	_____
RUBELLA	#1 _____	History of Disease Not Acceptable	_____	_____
VARICELLA	#1 _____ #2 _____	History of Disease Not Acceptable	_____	_____

**All equivocal titre results require an additional vaccine.

Disease	Immunization Dates	Declination Date	Date of Titre/Result
HEPATITIS B Series of 3 vaccines or Positive titre or Declination on file	#1 _____ #2 _____ #3 _____	_____	_____ Laboratory report needs to be attached

Tuberculin Testing (Mantoux, PPD). Tine not acceptable. Quantiferon may be used in lieu of PPD. **History of BCG is not reason to defer PPD.**		
Date Implanted:	Site implanted:	Manufacturer/Lot#/Exp. Date:
Printed Name of person implanting:	Signature of person implanting:	
Date read:	Result in mm: _____ ☐Significant ☐Non Significant	Erythema: _____ Induration: _____
Printed Name of person reading:	Signature of person reading:	

Quantiferon Blood Test: _____ Result: _____ Attach copy of test result.

Positive PPD/Quantiferon:
Date of Chest xray: _____ Result: _____ Attach copy of xray report.

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SSB ROOM 110

PHYSICAL EXAMINATION

Be completed by MD, PA, or NP
RN signature not acceptable

Name_____ **A#**_____

Height: _____ Weight _____ BMI: _____ Blood Pressure: _____ Pulse: _____

Vision: Right 20/_____ Left 20/_____ Corrected: ☐ Yes ☐ No Hearing: Right _____ Left _____ Aids: ☐ Yes

Date of Exam: _____

Check each item in the column, enter NE if not evaluated

	Normal	Abnormal	Notes/Details
Head/Neck/Scalp/Face			
Nose and Sinuses			
Mouth and Throat			
Teeth and gingival			
Ears			
Eyes (lids,conjunctiva, pupils etc.)			
Chest and Lungs			
Heart			
Vascular system (varicosities)			
Abdomen and viscera(hernia)			
Spine and Musculoskeletal			
Neurological			
Genitourinary System			
Anorectal			
Upper and lower extremities			
Skin and lymphatics			
Endocrine			

Urinalysis:	**Glucose**	**Bilirubin**	**Ketones**	**Specific Gravity**	**Blood**	**PH**	**Protein**	**Nitrites**	**Leukocytes**

Hemoglobin: _____ **Hematocrit:** _____

Has patient been treated for psychological problems, substance abuse, or eating disorders? ☐ Yes ☐ No

If yes, please describe:_____

Technical standards: Does this student have?

Any limitations in visual acuity	☐ Yes ☐ No	Any limitations in tactile ability	☐ Yes ☐ No
Any limitations in hearing ability	☐ Yes ☐ No	Any limitations in fine motor skills	☐ Yes ☐ No
Any limitations in physical endurance	☐ Yes ☐ No	Any limitations in strength and mobility	☐ Yes ☐ No
Any limitations in communication	☐ Yes ☐ No	Any limitations in emotional stability	☐ Yes ☐ No

Please describe any yes answers:_____

_____

Signature of Health Care Provider:_____

Address:_____ **Date of Exam:**_____

Phone: _____ **Fax:** _____ **Date Signed:**_____

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